ALABAMA BOARD OF NURSING
P.O. BOX 303900
MONTGOMERY, ALABAMA 36130-3900

IDENTIFICATION OF PRIMARY PHYSICIAN AND PRIMARY DENTIST

Name of Licensee	License Number	Case Number

Select Compliance Monitor	
___ VDAP Telephone: 334-293-5228 Fax: 334-293-5201 E-mail: abn@abn.alabama.gov	___ Probation Telephone: 334-293-5229 Fax: 334-293-5201 E-mail: abn@abn.alabama.gov

Your Agreement requires you to identify the name, address, and telephone number of your primary and other healthcare providers (including collaborating physician's information if your primary provider is a Nurse Practitioner) and primary dentist within fourteen (14) days of the effective date of your Order or Agreement. You are also required to disclose to your primary physician and dentist that you are being monitored by the Alabama Board of Nursing. Complete this form and submit it to the address above within the required time.

Primary Healthcare Provider's Name & Title (e.g.: MD, DO, CRNP) If your Primary Healthcare Provider is a Nurse Practitioner, you must include the NP's Collaborating Physician's Name & Title	
Practice Name and Complete Mailing Address	
Practice Telephone Number	
Primary Provider's E-mail Address	
Practice Website	

Primary Dentist's Name & Title	
Practice Name & Complete Mailing Address	
Practice Telephone Number	
Primary Dentist's E-mail Address	
Practice Website	

If you have additional specialty health care providers, please include all the above information on these providers on the back of this form. If there are changes in your health care providers, please re-submit this form with the new information.

I certify I have contacted my health care providers and disclosed the reason(s) I am monitoring by the Alabama Board of Nursing.

Signature of Licensee: _____ **Date:** _____